

WISCONSIN DIABETES MELLITUS ESSENTIAL CARE GUIDELINES 2008 (ONE-PAGE)

For details and references for each specific area, as well as the disclaimer, please refer to the supporting documents and implementation tools in the full-text *Guidelines* available via the Internet at <http://dhs.wisconsin.gov/health/diabetes/guidelines.htm> or telephone: (608) 261-6855.

Concern	Care/Test	Frequency
General Recommendations for Care	<ul style="list-style-type: none"> ◆ Perform diabetes-focused visit ◆ Review management plan; assess barriers and goals..... ◆ Assess physical activity level..... ◆ Assess nutrition/weight/BMI/growth 	<p><i>Type 1:</i> Every 3 months ❖</p> <p><i>Type 2:</i> Every 3 – 6 months ❖</p> <p>Each focused visit; revise as needed</p> <p>Each focused visit</p> <p>Each focused visit</p>
Self-Management Education	<ul style="list-style-type: none"> ◆ Refer to diabetes educator, preferably a CDE in an ADA Recognized Program; curriculum to include the ten key areas of the national standards 	At diagnosis, then every 6 – 12 months, or more as needed
Medical Nutrition Therapy	<ul style="list-style-type: none"> ◆ Refer for medical nutrition therapy (MNT) provided by a registered dietitian (RD), preferably one who is also a CDE..... 	At diagnosis or first referral to RD: 3 to 4 visits, completed in 3 to 6 months; then, annually. RD determines additional visits based needs/goals.
Glycemic Control	<ul style="list-style-type: none"> ◆ Check A1c; goal: < 7.0% (always individualize)..... (ADA recognizes goal of < 7.0%) (AACE recognizes goal of ≤ 6.5%) ◆ Review goals, medications, side effects, and frequency of hypoglycemia..... ◆ Assess self-blood glucose monitoring schedule 	<p><i>Type 1:</i> Every 3 months ❖</p> <p><i>Type 2:</i> Every 3 – 6 months ❖</p> <p>Each focused visit</p> <p>Each focused visit, 2 – 4 times/day, or as recommended</p>
Cardiovascular Care	<ul style="list-style-type: none"> ◆ Check fasting lipid profile..... Adult goals: Total Cholesterol < 200 mg/dL Triglycerides < 150 mg/dL HDL ≥ 40 mg/dL (men) HDL ≥ 50 mg/dL (women) Non-HDL (Cholesterol) < 130 mg/dL LDL < 100 mg/dL (optimal goal) LDL < 70 mg/dL (for very high risk) ◆ Start statin with ongoing lifestyle changes ◆ Check blood pressure..... Adult goal: < 130/80 mmHg ◆ Assess smoking/tobacco use status ◆ Start aspirin prophylaxis (unless contraindicated)..... 	<p><i>Children:</i> After age 2 but before age 10. Repeat annually if abnormal, repeat in 3 – 5 years if normal.</p> <p><i>Adults:</i> Annually. If abnormal, follow NCEP III guidelines.</p> <p>Adults with CVD; Age > 40 yrs with one or more risk factors for CVD</p> <p><i>Children:</i> Each focused visit; follow National High Blood Pressure Education Program recommendations for Children and Adolescents</p> <p><i>Adults:</i> Each focused visit</p> <p>Each visit; (5As: Ask, Advise, Assess, Assist, Arrange)</p> <p>Age > 40 yrs with diabetes; Age ≤ 40 yrs, individualize based on risk</p>
Kidney Care	<ul style="list-style-type: none"> ◆ Check albumin/creatinine ratio using a random urine sample, also called urine microalbumin/creatinine ratio ◆ Check serum creatinine and estimated GFR ◆ Perform routine urinalysis..... 	<p><i>Type 1:</i> At puberty or after 5 years duration, then annually</p> <p><i>Type 2:</i> At diagnosis, then annually</p> <p>At diagnosis, then annually</p> <p>At diagnosis, then as indicated</p>
Eye Care	<ul style="list-style-type: none"> ◆ Dilated eye exam by an ophthalmologist or optometrist 	<p><i>Type 1:</i> If age ≥ 10 yrs, within 3 – 5 years of onset, then annually</p> <p><i>Type 2:</i> At diagnosis, then annually; two exceptions exist</p>
Neuropathies and Foot Care	<ul style="list-style-type: none"> ◆ Assess/screen for neuropathy (autonomic/DPN) ◆ Visual inspection of feet with shoes and socks off ◆ Perform comprehensive lower extremity/foot exam (use monofilament and tuning fork) ◆ Screen for PVD (consider ABI) 	<p><i>Type 1:</i> Five years after diagnosis, then annually</p> <p><i>Type 2:</i> At diagnosis, then annually</p> <p>Each focused visit; stress daily self-exam</p> <p>At diagnosis, then annually</p> <p>At diagnosis, then annually</p>
Oral Care	<ul style="list-style-type: none"> ◆ Inspect gums and teeth for signs of periodontal disease ◆ Dental exam by general dentist or periodontal specialist..... 	<p>At diagnosis, then each focused visit</p> <p>At diagnosis, then every 6 months (if dentate) or every 12 months (if edentate)</p>
Emotional/Sexual Health Care	<ul style="list-style-type: none"> ◆ Assess emotional health; screen for depression..... ◆ Assess sexual health concerns 	<p>Each focused visit</p> <p>Each focused visit</p>
Immunizations	<ul style="list-style-type: none"> ◆ Provide influenza vaccine..... ◆ Provide pneumococcal vaccine..... 	<p>Annually, if age ≥ 6 months</p> <p>Once; then per Advisory Committee on Immunization Practices</p>
Preconception and Pregnancy Care	<ul style="list-style-type: none"> ◆ Provide preconception counseling/assessment ◆ Assess contraception/discuss family planning ◆ Assess risk for gestational diabetes mellitus (GDM)..... ◆ Screen for GDM..... ◆ Screen for Type 2 diabetes post-GDM..... 	<p>3 – 4 months prior to conception ◆</p> <p>At diagnosis and each focused visit ◆</p> <p>At first prenatal visit (if high risk, screen immediately for GDM) ◆</p> <p>At 24 – 28 weeks gestation or earlier if high risk ◆</p> <p>At 6 – 12 weeks postpartum, then annually</p>
Identification and Diagnosis of Pre-diabetes and Type 2 Diabetes	<ul style="list-style-type: none"> ◆ Perform fasting plasma glucose test or oral glucose tolerance test 	Test all adults ≥ age 45 yrs (see full <i>Guidelines</i> for testing of Type 2 diabetes in children and adolescents); if normal and person has no risk factors, retest in 3 years or less

❖ consider more often if A1c ≥ 7.0% and/or complications exist

◆ consider referring to provider experienced in care of women with diabetes during pregnancy